

HARVARD MEDICAL ALUMNI BULLETIN

January, 1953



Bulfinch on Roundsmanship



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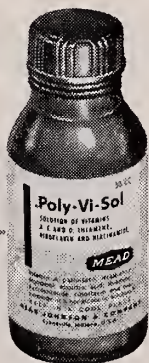
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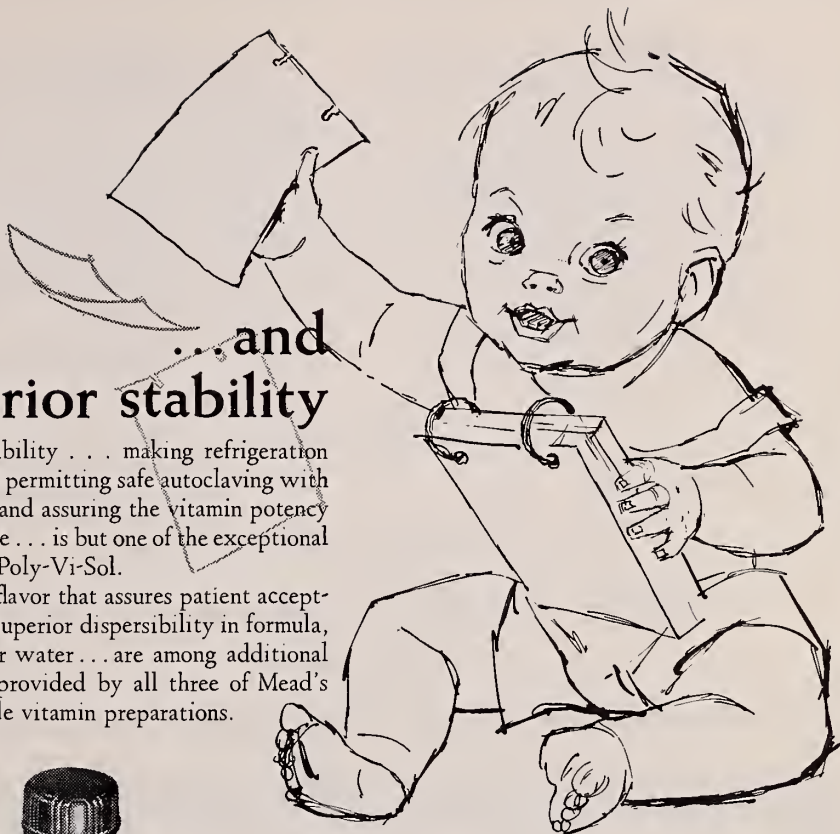
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MR. CONANT LEADS THE PROCESSION OCTOBER 7, 1933

Mr. Conant

The minutes of the meetings of the Faculty of Medicine reveal that on Friday, October 6, 1933, for the first time, Mr. Conant presided in his official capacity as President of the University. Forty-nine members were present and of these sixteen are still active; all were interested in seeing the new President and all wondered, too, what kind of a man had taken the helm.

On the next day, the School observed its one-hundred-and-fiftieth birthday. This was a memorable occasion. Among other interesting happenings in Sanders Theatre, where the academic part of the celebration took place, Mr. Conant made his first public appearance as President before medical students and alumni and delivered what the program listed as "a short introductory Oration."

His remarks are interesting to re-study twenty years later, at the end rather than at the beginning of his term in office. In 1933 he said that the School had become one of the great centers of medical research and education. He credited the creation of the medical faculty as the first step in changing Harvard College into the famous University that it has become.

When Doctors Warren, Waterhouse and Dexter became professors, there were only three other professors on the rolls, hence the Faculty immediately became heavily weighted on the side of medicine. The influence of these three on the intellectual life of the College must have been profound; how much this was appreciated by the whole student body may be judged from the fact that the undergraduates protested vehemently when the medical faculty left Cambridge.

Mr. Conant emphasized that under Mr. Eliot's guidance, and later under Mr. Lowell's, the connecting threads between the Harvard community in Cambridge and the medical faculty in Boston had grown stronger and were much less tenuous than during the period between 1810-1869 when the School was essentially a separate, proprietary institution. Mr. Conant regarded

what Mr. Eliot and Mr. Lowell had accomplished along these lines as of particular significance. "In a University," he said, "it is essential that those who are devoting their lives to one specialty may have the privilege of being associated with the leaders in entirely different fields. The catalytic value of such association is incalculable both from the point of view of the faculty and of the students."

He believed that the relation of medicine to the sciences of biology, chemistry and physics, had become very intimate and that in all probability future advances in all science, including medical science, would be made largely by co-operative efforts. "If effective investigations are to be carried on in a modern university," he added, "there must be present a group of brilliant men with sufficient skills at their command and with a willingness to aid each other whenever possible. In addition there should be the possibility of frequent informal meetings to discuss mutual problems. If these conditions are fulfilled, significant research is sure to develop."

In 1953, during Mr. Conant's administration, the Harvard communities in Cambridge and Boston have continued to grow closer together. There are biologists, chemists and physicists in Cambridge and in the medical school who meet frequently and aid each other whenever possible. A medical professor lectures regularly at the Law School, students working for higher degrees in the medical sciences are under the administration of the Faculty of Arts and Sciences, are registered in the Graduate School of Arts and Sciences but do the bulk of their work at the Medical School. A doctor lunching at the Faculty Club in Cambridge feels fully as much at home and sees as many friends as when he lunches in the Club Room of Vanderbilt Hall. The realization that to be a member of the Harvard Medical Faculty automatically makes him a member of one of the faculties of Harvard University has had far-reaching results in the Medical School—better teaching, more im-

Roundsmanship

HENRY JACOB BULFINCH, '56

They think that they shall be heard for their much speaking. (Matthew, VI, 7)

Stephen Potter has done great service to civilization by defining certain principles of conduct which he has identified as Lifemanship.¹ This is best illustrated by its fundamental axiom, "If you're not one up, you're one down." Perhaps nowhere is Lifemanship better found than at what at inside* hospitals is called Grand Rounds.

Reflection on the term "Rounds" confirms one's faith in the power of the English language to bewilder. What formerly was an occasion upon which a group of doctors walked together around the wards dispensing knowledge and healing suggestions has become a weekly carnival having for each who attends some special significance. For some, particularly the nurses, it is a refuge from the hurly-burly of their duties; for others, an educational exercise both to give and to receive. For many it is a chance to sit back** and enjoy the passing scene in which the Houseman, the Rowman, and—at times—the Patient, figure so prominently. It is the Housemen and the Rowmen who create the atmosphere of Rounds known to Galen, that Master Roundsman, as the "Aura Roundseals", and it is to them, that the principles of Roundsmanship apply.

Between the two, the Houseman and the Rowman, there exists a struggle that is Martian in scope. The Houseman, dressed in white as befits his tender years, is the champion of trial and error. To him is allotted the first move. The Rowman, by contrast, is on the side of accumulated

wisdom and clinical experience. To a certain extent he is at the mercy of the Houseman, but even more, he is at the mercy of the other Rowmen who occupy the rows or benches in definite order: Frontrowmen, Secondrowmen, and Backrowmen.

I. HOUSEMANSHIP

Since it is the Houseman who arranges the events of the carnival, we must first direct our attention to the rules and general principles which govern his conduct, not overlooking certain pitfalls and grave errors into which he may fall.

Since the Houseman knows what the events are to be, he has little interest in the show itself other than to practice Housemanship in order that when the hour ends he will be one up and the Rowmen one down. Ordinarily he will do well to see to it that so far as he is concerned the one-downness is not confined to any one Rowman but to all the Rowmen as a group. There are many ways to accomplish this which for convenience we will divide into three categories, Houseman-Rowman play, Houseman-Patient play, and the Proper use of Props.

A. Houseman-Rowman play

Since the Houseman makes his first contact with the Rowmen when he begins to present the case at hand, the traditional opening gambit is to give the patient's chart to the Frontrowman who holds the lowest position of those present, rather than to the senior man. This does not necessarily annoy the senior man, but is most effective in irritating the other Front-

portant and significant research of a fundamental nature and, by combining better teaching with greater knowledge from research, better care of patients.

The Medical School—students, faculty, alumni—will miss President Conant, not only for himself but because for the past

twenty years his influence and leadership in medical education has been so forceful, forward-looking and wise. During the next twenty years, wherever he goes, in whatever he does, he will carry with him the admiration, gratitude and respect of the Harvard Medical Alumni Association.

*To distinguish them from "outside" hospitals.

**Or, in some cases, to sit hunched forward, head in hands.

rowmen because protocol has been so hideously violated. If a Secondrowman has by some indiscretion taken a position in the front row, or if he has been trapped there from a previous rounds, it is most effective play to hand the chart to him.

Another unfailing way for the Houseman to score is to present a case in which treatment has been unsuccessful or some unforeseen dire complication has supervened. This should be reported in a matter-of-fact, rather diffident tone of voice, a "bad-luck-but-there-it-is" sort of attitude. The same situation may also be dealt with by assuming a super-professional, calm demeanor, talking down to Rowmen in much the same manner in which the anxiety of the patient's family was allayed on the previous day.

This is a potentially disastrous play, however, which may well leave the Houseman "one down" if the Frontrow is united in its horror of the direct violation of time-honored custom. Wise is the Houseman who splits the Opposition by injecting into his presentation a non-sequitur about which there is an emotional rather than a rational disagreement.

In Housemanship the element of mystery must never be neglected. The point of the presentation and the nature of the problem should be suitably obscure. The advanced Houseman can bring the Rowman to a point of frustration at which he will attempt to elicit the essential information by questions that he will hardly dare ask for fear that the information has in fact been given out but that due to his inattention he has missed it. To ask for it now would make him lose face. Whether he asks for it or not, it is good Housemanship to have created the conflict.

Much can be made of presenting a patient *en surprise*, that is, failing to notify the Rowman who has operated upon the patient that his handiwork is to be on display. The Rowman will, therefore, have no prepared remarks and will not, it is hoped, have had time to look up the one significant article on the subject. He will thus be torn within himself as to how much to say about the case. Conflict again will have been created. The situation can

be further exploited by the Houseman if he makes a point of removing the appropriate volume from the library several days before and perhaps even reading from it after the Rowman has stammered out his garbled and ineffectual words.

In the same vein, a situation of strength can be created by inviting a member of the Medical Staff to discuss a case with a prepared speech and slides for perhaps thirty minutes of an hour in which the showing of six cases had been planned. Though this may contribute greatly to the education of the representatives of the Nursing School and Medical Arts Department seeded among the Backrowmen, it produces little but a restless ferment among those down front.

B. *Houseman-Patient play.*

The trained Houseman becomes expert in his handling of the patient. Nothing, for example, so breaks the ice as the presentation of an infant surrounded by all the trappings of childhood; balloons, stuffed animals and the like. On such occasions the close observer will be mildly startled to see several of the Frontrowmen surreptitiously trying to win the attention of the tiny patient who according to time-honored custom is presented as "Mister" or "Miss" Bizbee. At the other end of the scale, a spry elderly patient should be introduced as of something greater than her actual age. This will be immediately corrected by the patient and if the Houseman can then manage to blush prettily, he has scored again. By contrast, it is distinctly poor play to ask the patient how he or she feels since only one reply is acceptable.

Many broad points of policy must be decided in the handling of patients. Much can be said for rushing the bed in and out so fast that no one can be sure whether or not it actually contained a patient. By contrast, the patient may be kept throughout a long and complicated presentation, during which preferably he should lie curled up in a ball, back to audience, with face covered. A particularly effective form of Housemanship is to present three to five patients at once, so that the amphitheatre furnishes a scene of intense ac-

tivity not dissimilar to a Bruegel canvas.

Bed crashing is best reserved for patients who are no more than one day post-operative. As the bed is run solidly against the door jamb, a barely audible murmur of "shame, shame" can be made out running through the audience. If the bed in question is equipped with a five-pint bottle hanging from its side, the effect is heightened. A particularly useful maneuver is to arrange that a constant drainage catheter or common-duct tube should drain not into the bottle, but onto the floor during the presentation of the case.

C. *The proper use of props.*

Aside from the patient and his various appurtenances, the Houseman has at his disposal only a few props, chief among which is the x-ray viewing box. With proper use, however, much can be made of this. It is axiomatic, for example, that at some time during the rounds films should be displayed in a reversed position—so called *situs inversus radiologicus*. The combinations possible with spotfilms are inexhaustible. A particularly useful maneuver is to drag the viewing screen forward so that all may inspect the films more closely. At the critical moment the light cord to the apparatus becomes inadequate and all is dark. Great effect can then be created in the efforts to restore illumination.

Much can be done by the proper use of the pathological specimen. During the presentation of the patient, it should be kept in a prominent place discretely covered by a voluminous pile of wet rags or sodden paper towels. It should always repose upon an evil-looking enameled platter or in a battered and obviously contaminated basin. As the patient is wheeled out, the trophy is then triumphantly unveiled, quickly thrust upon the nearest Frontrowman with the suggestion that it be circulated freely so that all may share its contagion. So far as possible it should be arranged that the pathologist has taken sufficient sections from the key point of the specimen so as to make orientation virtually impossible.

II. FRONTROWMANSHIP

The Frontrowman occupies a key position in the structure of Rounds. His place is more than to sit in judgment, he represents continuity and accumulated wisdom. This is to be scattered among the pilgrims who have come to learn. At the same time, he must defend his place among his peers and guard himself from the Houseman. His techniques are many.

The authority and stature of a Frontrowman is often demonstrated by the degree with which he undertakes to converse with his neighbor while a case is being presented or another individual is discussing it. In effect, he creates a diversion. If this is aimed at the Houseman, it can be made most effective by inclining one's head towards a neighbor, looking the Houseman directly in the eye and asking in a stage whisper, "What's this boy's name?" The answer, "Don't know—must be a striker," virtually assures triumph.

A very useful form of Diversionship is to whisper to one's neighbor in tones inaudible even to him some witticism of any quality, followed immediately by a loud chortle or scarcely subdued laugh. The neighbor can only nod his head vigorously and smile wanly. The impression, however, will have been created among the Houseman and Rowmen alike that some priceless thing has been said or done which they in their dull-witted or inattentive state have failed to appreciate.

There is the technique for capturing the center of the verbal stage by the judicious interruption. This requires finesse that comes of years of experience and should be done in a way that the other members of the audience relish. Perhaps the surest method is that of the interrogative sentence. This is a question which during its first few words sounds as if the asker were really requesting information. A deft Frontrowman, however, can easily, without drawing breath, allow the words to reorient themselves so that instead of asking, they tell. Thus, if a patient has had necrosis of a colonic suture line following resection, one can say, "Knowing very little about these matters, I should like to

ask whether you don't think it is wise to examine the bowel near the resection edge for pulsating vessels?" One thereby creates the effect that (1) he knows a great deal about these matters; (2) that with razor sharpness he has come straight to the heart of the matter.

No positive statement on the part of a Houseman or Secondrowman should be allowed to pass without some qualification by a Frontrowman. This can often best be done by citing from one's own experience examples of somewhat similar cases which really have little bearing on the subject at all. For instance, if a patient is presented as an example of the benefits of a given treatment A, the deft Frontrowman will not discuss treatment A (with which indeed he has had no experience), but merely describe with warmth and humor a case which he has handled with brilliant effect by treatment B, the method long established as the best, although not always adequate, one.

Complete denial of a positive statement made by a Junior is best handled by Distortionship. After a judicious interruption, the Frontrowman proceeds sonorously down the verbal stage with a definite sequence of moves: (1) expression of great interest in what Doctor Doe has said; (2) direct misstatement of Doctor Doe's argument prefaced by "If I understand you correctly"; (3) entire agreement with the revised, mirror-image version of Dr. Doe's argument. An authoritative impression of good fellowship is thus created except in Dr. Doe, whose meaning having been exactly reversed by Dr. Frontrowman, realizes that he has been had again.

The courageous and righteous castigation of the Houseman for some minor error in the handling of a case is always effective in creating an impression though it can only be done by One Who Has Arrived. The Frontrowman, however, must be continually *en garde* lest he is being mouse-trapped into a display of platitudes. A method of correction that invariably succeeds is to read from the record any significant item which, in his presentation, the Houseman has failed to incorporate,

or has quoted incorrectly. Much can be gained by an obviously careful perusal of a patient's new, or old, record, with an occasional aside to one's bench-mate. Unless the Houseman is exceedingly well briefed in the case at hand, or has taken the precaution to see that the record has not fallen into the hands of a known Record-reader (see Sec. A, Part I, Housemanship) he can usually be put completely off balance.

Humility has many uses to the Frontrowman. Should a Backrowman ask a question that defies answer, the alert Frontrowman will hesitate, verbally, to reply to the question. Then, while pleading *nolo*, he will nail another Frontrowman by tossing the ball directly in his lap, thus: "Perhaps Doctor Throop would be willing to answer that question since he knows more about these matters than I." Dr. Throop, of course, does not, but feels impelled to say something. This thoroughly discredits him for the balance of the Rounds and Frontrowman A emerges as the humble handservant of Truth. The Backrowman is more confused than ever and wishes that he had not asked the question. The whole episode serves to discourage further questions from the Backrowmen and thus a proper *Aura Roundsealis* is preserved.

A successful gambit may be occasionally achieved by complimenting the Houseman and his associates effusively on the management of a case. This is particularly effective if the patient really represents a rather mediocre result of what is, at best, a questionable form of treatment. The Frontrowman should purposely misinterpret the result to be an excellent one. This ostensibly magnanimous maneuver creates a sense of uneasiness in the Houseman who knows the result is not a good one, knows that the Frontrowman knows, and cannot understand his motive in using the Patronship play.

There is one prestige maneuver, namely Camaraderieship, that is of great utility. In essence, Frontrowman A, finding himself cornered in argument with colleague B, quotes as his authority leading figures in other medical capitals whom he refers

to by their nicknames, thus: "When I was last in London, Archie Heneage told me that he had given up cutting the stem cryptoleus and relies entirely upon drainage through the pytaloid apparatus." The drawback to this form of play is obvious. Frontrowman B, having been given the green light, may be able to quote celebrities faster than A. If play is then conducted along these lines, much prestige may be lost by both A and B as nicknames fly back and forth like pillows in a pillow fight. A surer form of Camaraderieship is to introduce a member of the international set to the front row. If this figure can then be lured into making a few suitably obscure remarks or will, at the appropriate moments, nod and grunt knowingly, his sponsor has indeed scored.

III. SECONDOWNMANSHIP

The Secondrowman may be considered a larval stage. He will fall into one of three categories: assistant surgeons of the regular staff, middle-aged regular attendants at Rounds who possess considerable stature in their own "outside" community, and Fourthfloormen.* The Secondrowman operates according to the general rules of order laid down for his seniors. Thus he may create a diversion, interrupt, qualify, distort, be humble or expound.

The Secondrowman ordinarily should be humble, with one exception to be noted later. Thus he should apologize for the presentation of one of his cases in some such manner as: "I thought at the last minute that it would be worthwhile to bring this patient down since he perhaps illustrates one or two interesting points." This creates the impression that in the rush of practice he has been able to gather his wits long enough to recognize a problem when he sees one, but not long enough to prepare a discussion of it. The discussion which follows must be carefully given in a halting and hesitating man-

ner so as not to betray the two hours of rehearsal which had been secretly devoted to it the night before.

The Secondrowman, middle-aged-regular-attendant type, is expected to look pleasant and relaxed and to say very little. He should, however, fill in the awkward gaps in the proceedings which occasionally occur, by telling of an interesting case with which he has just been confronted. This should never be done with an air that would lead anyone to suspect that such cases are not often seen in this large teaching center. It should be accompanied by an earnest attitude as if seeking guidance and advice. Since no advice will be forthcoming the remarks should be brief.

The Fourthfloormen's contribution to Rounds should be preserved as a very special one. He has come to deliver a Message and the Message will be good. He should come to Rounds early and be discovered checking formulae that he has put upon the board by doing quick calculations in the corner using Greek letters and a slide rule. A bit of unusual apparatus which blinks balefully and which emits ominous and cosmic ticking sounds can create a superb atmosphere of suspense and anticipation. The Message must be a crisp one. It need not instruct. It need not be clear. But it must be authoritative. Camaraderieship is usually out of place, but there should be implied a complete familiarity with and mild contempt for other prominent workers in the field, their co-workers and their laboratories.

If the Message has been delivered correctly, there will and should be no discussion. An admiring silence will ensue, broken only by the Houseman jouncing in the next patient, who, if the Fourthfloormen has arranged things properly, should represent the most banal of problems such as a case of appendicitis treated by appendectomy.

IV. BACKROWMANSHIP

Backrowmanship, as has been implied above, is merely the art of sitting still.

REFERENCE

¹Potter, S. Lifemanship. Henry Holt & Co., New York, 1950.

*It is recognized that this term may be a local one and perhaps Researchman, or even, as some have suggested, Trainedsealman, might be more appropriate. However, the "Fourth Floor" is so distinctive a place, the author has chosen to preserve this terminology.

In Defense of Medicine as a Profession

HENRY SWAN, '39

Syllogism

1. Medicine in the United States is practiced primarily by graduates of American Medical Schools.
2. The quality of medical care depends primarily on the ability, training and motivation of medical practitioners.
3. Ergo: Medical education in America has a decisive influence on the nature of medical practice in the United States.

I

Fortunately, most medical educators in America today accept in general the responsibilities and obligations implied in the above proposition. Though medical education may be beset with difficulties in our modern era of scientific revolution, of costs and taxes, and of social evolution and unrest, yet few responsible educators would seek to ravage with deliberate intent the fundamental and traditional bases of medical practice. There are values in America's conception of the profession of medicine, intangible, difficult of definition, spiritual perhaps, which are the heritage of three thousand years' survival of a conception of principles and ethics in the behavior of the physician molded by a society still admitting the importance of the individual. The revolution in science has changed only the scope and the methods, not the objectives, principles, and inner relationships of that powerful yet nebulous core of traditions, tenets, codes, faiths, and urges which, self-imposed, comprise the unrelinquishable nucleus of what we term the "profession" of medicine.

Medical education seeks to promote the quality and extend the boundaries of medical care. It clings to the concept of medicine as a profession, and considers this concept a prerequisite for the accomplishment of these objectives.

To those who believe that medical

practice is more than a trade or craft, how shocking it was to read in the columns of this *Bulletin* a frontal attack on the foundations of medical practice, written from the point of view of the laboratory investigator, and camouflaged to some extent under an innocuous title "*The Hidden Price Tag. A Study in Medical Research.*" Dr. L. S. King was really expounding a theory of medical practice, and suggesting a revolution in medical education based on this theory. The "hidden price tag" of his proposals would be the abasement of the medical profession to the level of medieval tradesmanship.

II

The attack on medicine as a profession, as outlined by Dr. King, may be summarized somewhat as follows:

- A. The practice of medicine is a purely technical occupation, similar to the trade of a garage mechanic.
("The medical practitioner is actually a technician, completely analogous to the radio repair man, the electrician, or the automobile mechanic.")
- B. The practitioner of medicine, therefore, does not need much training in the background of medical science, nor does he require a liberal education.
("It would be possible to train very competent medical practitioners easily in five years after high school graduation.—Liberal cultivation of the intellect is not a part of professional training.")
- C. That scientific knowledge may accumulate on which to base the technical practice of medicine, trained "medical scientists" must exist to perform "research." The "scientists" would have no direct connection with the practice of medicine.

('We must realize the necessity for two types of physicians: the practitioners, who are technicians; and the much smaller number of medical scientists—who will deal with the theoretical background of medicine, who will grasp the inner relationships and causes, who will extend our knowledge; [for the scientist] a training of at least twelve years is necessary.'")

It is interesting to contemplate some of the corollaries or implications of these arguments. Is it possible the author would urge seriously the validity of the following short list of statements, most or all of which, however, must be maintained if the main argument is to be considered sound?

1. The practice of medicine consists of the treatment of symptoms or occasionally of easily identifiable disease entities; it does not entail the treatment of the patient who has the symptoms or the disease entity.
2. The practice of medicine does not include prevention of physical and/or mental disease, nor the maintenance of good health.
3. A knowledge of the scientific background of medicine is unessential in evaluating diagnostic tests or therapeutic means.
4. An inquiring or investigative mind is not only unnecessary but probably detrimental to the practicing physician.
5. A broad understanding of the social, intellectual, artistic, and psychological facets of mankind is unrelated to the treatment of the sick individual.
6. The practice of medicine is not intimately concerned with complex, important, fundamental human values.
7. The practice of medicine is solely a means of livelihood, without ethical or moral facets, or intrinsic values.
8. The practitioner of medicine has no self-imposed moral or ethical obligations to his patient.
9. Continuing self-education is unessential for the practicing physician.
10. "Pure" research, unrelated to possible practical application, has been responsible for the advances in medicine; "applied" research is unimportant.
11. The importance and application of pure scientific discoveries would be best recognized and tested by the scientist, divorced from the practice of medicine.
12. The advances of medicine in the past have been made primarily or exclusively by the laboratory "scientist."
13. The research scientist is the best teacher of medicine.
14. The only teachers of medicine should be the "medical scientist."

If these be Dr. King's beliefs, it is indeed fortunate that his activities in medicine have been confined to "pure" research. Nonetheless, his query is provocative. What are those qualities of the practice of medicine which characterize it as a profession, which must be considered essential to its nature, and which have complicated the training of its practitioners?

III

Webster's definition of a profession is subtle and meaty. "Profession. 4. The occupation, if not purely commercial, mechanical, agricultural or the like, to which one devotes oneself; a calling in which one professes to have acquired some special knowledge, used by way of instructing, guiding, or advising others or of serving them in some art."

The first, and perhaps most crucial quality then, is that the profession of medicine concerns itself with man. It purports to influence in action important human values of other individuals and groups of individuals. It must necessarily operate in conception and in practice at a different level than those occupations which concern themselves with things. In the minds of men, human values are qualitatively of a different and higher order than those re-

lating to inanimate objects or to other living species.

Secondly, its internal bonds consist of a network of self-imposed obligations. Its practitioners accept and dedicate themselves to a concept of moral and ethical relationship to other people. To some extent, through long practice and custom, the definition of these relationships has found its way into law. In other areas, however, these obligations remain self-enforced as being of inherent importance. To say that these tenets are uniformly adhered to is, of course, absurd. Physicians, it must be remembered, are also men and to stray is human. This does not alter the fact that the self-imposed code of ethics comprises an important qualitatively distinctive characteristic of the profession.

Its product is service; "used by way of instructing, guiding, or advising others or of serving them in some art." The quality of the service depends on a training which combines a complex maturation of intellect, motivation, and skill. The physician "professes to have acquired special knowledge," and, to be competent, must in fact have done so. He must also have acquired understanding, personal stability, and compassion. Since the area of special knowledge is large, the period of training must of necessity be long. Medicine is inherently a "learned" profession; the road to fellowship cannot be short.

An interesting quality of the profession is its intrinsic drive toward advances and improvement in knowledge and methods, not merely to achieve knowledge per se, but to the end that its service may be more effective. This constant search for better service does not specifically benefit the profession itself—economically or socially. Neither penicillin nor cardiac surgery enhance the esteem of the profession in the minds of men. Improvements in means are expected; the ethical relationships remain the primary distinctive quality of the profession. Nonetheless, the search continues, and in few areas of human endeavor have quantitative advances been more extensive.

Lastly, there is a strength in aspirations.

Qualities of the spirit are present to greater or lesser degree in most physicians which partially explain, perhaps, why they are physicians—qualities of compassion, of faith, of humanity. While seldom if ever fully achieved, the aspirations of these qualities of spirit stand as one of the strong forces for good in the realm of human relationships.

IV

Fortunately, most men concerned recognize that medical education must help develop in the student those qualities and attitudes which will serve to promote and preserve the standards of medical practice. Since the background volume of scientific data is currently undergoing violent expansion, and since changing social patterns are presenting serious economic problems, to say nothing of the effect of insurance coverage and federal medicine on the flow of clinical teaching material, it is small wonder that the difficulties which beset the medical schools today are great. Medical education is perhaps the most complex of any of the higher training processes.

It is interesting that one of the best statements regarding the objectives of medical education has been penned by a group of specialists. Not only are the observations cogent, but the source is illustrative of the fundamental necessity that the practitioner of medicine is a physician first, a specialist only secondarily. For fun, the reader might try to guess the origin of the following quotation before turning to the reference.¹

"Medicine deals with the human being; the primary objective of medical education is therefore the appreciation of man, his behavior and environment. This appreciation includes man's genesis, growth and maturity, his nature and the effects upon him of the buffeting which he receives from all sides. In addition to physical

¹Report to the American Surgical Association of its Committee on Undergraduate Education, April, 1950.

trauma, disease, and the wearing of age, this buffeting includes the opposing drives of emotional forces, his needs and dislikes and the influence of social custom. To accomplish this understanding of man, the student must be helped to insight into his own personality, and its effect upon the patient.

"Uppermost in the aims of medical education is that the graduate should seek a high standard of medical practice. The ambition of the student is ordinarily well formulated before he enters medical school. It should be molded by the medical faculty at every turn to strengthen the sense of social responsibility. ***** The student must be given sufficient understanding of the breadth of medicine for him to know his own limitations. ***** The medical school must foster scholarship. The student must have an elasticity of mind and be well founded in his habit of study; how else will he grow with medicine?"

These statements, Dr. King should note, were written by men in the active practice of medicine. They know that the subject of medical care is man, an intricate biological system of physiologic and psychologic complexes, with a group environment involving intrinsic values, not a simple, inert, and inherently valueless col-

lection of matter, such as a carburetor or an electronic computer. They know that the advances in medicine have stemmed not primarily from "pure" science but, to a much greater extent, from the trained, inquiring minds of investigators seeking answers to specific practical problems. They know the importance of an attitude of critical self analysis and of a sense of social responsibility. They know that medical education is faced with difficulties, that much research is mediocre, that all physicians are not perfect. But they know, too, that the answer to these problems does not lie in undermining and destroying the values inherent in the profession by turning out uneducated technicians to dispense drugs and incisions.

The practitioners of medicine engage in a profession with a proud heritage of intellectual, moral and ethical concepts which, self-imposed, comprise its major strength. The process of medical education is complex and currently beset with problems. The solutions to these problems must be sought in the full light of the importance of the relationship between education and the preservation and evolution of what is best in the standards of medical care of the profession.

Curare and Sherlock Holmes

EDWARD J. VAN LIERE, '20

"There passed not a minute, I believe, between health and death." *Samuel Johnson.*

Curare is used as a lethal agent by Sir Arthur Conan Doyle in two of his Sherlock Holmes stories. In his novel, "A Study in Scarlet," he takes liberties with the pharmacologic properties of curare, in that he ascribes actions to this agent, which due to its method of administration, it could not possibly have had. In the short story, "The Sussex Vampire," however, he employs curare scientifically and with telling effect and, indeed, builds an interesting plot around this agent.

The word "curare" is a generic term which is applied to many South American arrow poisons. Although supposed to be of Tupian (i.e. from the Language of the Tupi Indians) origin it is not actually an Indian word. The Brazilian naturalist, Rodrigues,¹ claimed that the Indian name for the poison was, "uiraery," which is really a phrase meaning, *uira*, "bird," and *eor*, "to kill." It is believed that the word curare represents the attempts by Europeans to reduce to phonetic equivalents the Indian phrase meaning, "to kill birds." There are, as would be expected, many variants of this word. Martius² preferred *uirary* and believed it compounded from *ur* "to come" and *ar* "to fall." This is also the derivation given by Webster's dictionary. Be that as it may, curare has been used for centuries by the Indians of the South American continent and is frequently spoken of as "South American Indian arrow poison." It is prepared commonly from the plants of the genera *Chondrodendron* and *Strychnos*. Historically it is of interest to mention that it was brought to Europe from Guiana by Sir Walter Raleigh in 1595.

Why was it that Sir Arthur was so in-

terested in curare? The answer is not difficult. He studied medicine at the University of Edinburgh from 1876 to 1881. Presumably physiology was given in the freshman year and doubtlessly curare was used in some of the laboratory experiments. About 19 years before Sir Arthur entered Medical School, that is, in 1857, Claude Bernard, the famous French physiologist, had made a careful study of curare. He had brilliantly demonstrated that a curarized muscle no longer responded to stimuli when its nerve was stimulated, whereas, if the muscle were stimulated directly, it reacted as usual. This actually proved that muscle had independent irritability, that is, a muscle could react to a stimulus without the intervention of nerves.

This exotic drug with its romantic history must have appealed strongly to the highly imaginative Doyle. At the time he wrote about curare in his Sherlock Holmes stories it was a relatively unknown preparation as far as the public was concerned. Sir Arthur probably felt that due to its novelty, its strangely lethal action, and its bizarre background it could be used effectively in his detective stories. He surmised correctly.

Let us first examine the role curare played in the novel "A Study in Scarlet." Holmes, it will be remembered wished to determine the toxicity of certain pills and instructed Doctor Watson to fetch a little dog, which already was *in extremis*. ". that poor little devil of a terrier which has been had so long, and which the landlady wanted you to put out of pain yesterday." Watson commented on the state of the animal. "Its laboured breathing and glazing eye showed that it was not far from its end. Indeed, its snow-white muzzle proclaimed that it had already exceeded the usual term of its existence." Then according to Doctor Watson

¹Curare: Its History, Nature, and Clinical Use. A. R. McIntyre. University of Chicago Press, Chicago, Illinois. P. 1, 1947.

²*Ibid.*

some of the pills which were thought to contain curare were dissolved in milk and offered to the sick dog. "The unfortunate creature's tongue seemed hardly to have been moistened in it before it gave a convulsive shiver in every limb and lay as rigid and lifeless as if it had been struck by lightning."

Before we comment on the sudden death of the terrier let us see what befell Enoch Drebbler, who was forced by Jefferson Hope to swallow a pill containing curare. The wretched Drebbler met the same fate as the aged terrier, for we find Watson writing: ". the action of the alkaloid is rapid. A spasm of pain contorted his features; he threw his hands out in front of him, staggered, and then with a hoarse cry, fell heavily upon the floor. I turned him over with my foot, and placed my hand upon his heart. There was no movement. He was dead."

The death of Drebbler and the terrier was dramatically portrayed and Sir Arthur is to be congratulated on the vivid picture he presented and on his originality. The trained scientist, however, could not entirely accept the events as outlined by Sir Arthur. The difficulty lies in the fact that curare is relatively harmless if taken by mouth. If extremely large doses are administered on an empty stomach, sufficient curare might be absorbed to cause grave symptoms, but death would not be instantaneous, for absorption is slow from mucous surfaces. If, on the other hand, there were an open lesion in the stomach or the upper part of the small intestine, such as an ulcer, then rapid absorption could take place and death would ensue within a relatively short time, although not as rapidly as portrayed by Sir Arthur. The action of curare is rapidly lethal only if injected directly into the blood stream.

Sir Arthur, then, took certain liberties when he chose curare as an agent to produce sudden death of the terrier and Drebbler. It would stretch our credulity too far to assume that both the dog and man had either a gastric or duodenal ulcer. If a suggestion may be permitted, Sir Arthur

should have used cyanide. This agent in small amounts kills quickly—even though it be taken by mouth. It is one of the most rapidly acting lethal drugs known. It acts by paralyzing the respiratory enzymes of the body. Respiration ceases and the patient dies of oxygen want. Sir Arthur no doubt was familiar with the action of the cyanides, but we may believe that their use did not suit his purpose. He preferred a less well-known and more exotic agent, such as the South American Indian arrow poison.

Let us now consider how Sir Arthur employed curare in his short story, "The Sussex Vampire." It will be recalled that Sherlock Holmes was asked by Mr. Robert Ferguson to investigate certain irregularities in his household. Ferguson, a fine gentleman, was very much in love with his beautiful Peruvian wife, but one day to his infinite horror he had actually seen her sucking blood from a wound on the neck of their year-old baby. She refused to make any explanation and the husband and wife became estranged. There was another child in the family, an invalid boy of 15, who was Ferguson's son by a previous marriage.

Doctor Watson accompanied Sherlock Holmes to Ferguson's country home on "a dull, foggy November day." One of the rooms of the old house contained a fine collection of South American utensils and weapons, which presumably had been brought from Peru by the mistress of the house. As Holmes was examining this interesting collection the movements of a dog attracted his attention. "A spaniel had lain in a basket in the corner. It came slowly toward its master, walking with difficulty. Its hind legs moved irregularly and its tail was on the ground." When Holmes asked what ailed the dog, Ferguson replied: "That's what puzzled the vet. A sort of paralysis. Spinal meningitis he thought. But it is passing. He'll be all right soon" Holmes asked a few more questions about the dog and finally remarked: "Very remarkable. Very suggestive."

The frantic husband insisted that Holmes tell all he knew or suspected; the great detective remarked: "Did it not occur to you that a bleeding wound may be sucked for some other purpose than to draw the blood from it? Was there not a queen in English history who sucked such a wound to draw poison from it?" Ferguson was astounded at the implication. Holmes continued: "A South American household. My instinct felt the presence of those weapons upon the wall before my eyes ever saw them. . . . When I saw that little empty quiver beside the small bird-bow, it was just what I expected to see. If the child were pricked with one of those arrows dipped in curare . . . , it would mean death if the venom were not sucked out." When asked about the dog: "And the dog! If one were to use such a poison, would one not try it first in order to see that it had not lost its power?"

Holmes then gently explained to the indulgent father that his 15-year-old invalid boy was so insanely jealous of his healthy baby half-brother that he had tried to do away with him by wounding him with an arrow which had been treated with curare. The mystery was solved and Holmes and Watson had the keen satisfaction of clearing up the grave misunderstanding between Ferguson and his lovely Peruvian wife.

In this story Sir Arthur handled curare in an expert manner. It is known, of course, that the South American Indians dipped their arrow-heads into a curare solution before using them to kill birds. The curare was rapidly absorbed from the wound made by the arrow; the wing muscles became paralyzed and the bird plummeted to earth—an airplane without wings.

Seventy-five years have elapsed since Sir Arthur used curare in his laboratory experiments. What is the status of curare now? This interesting compound has actually insinuated itself from the jungle not only into the experimental laboratory, but into the surgical amphitheater as well. This is not the place to take up in detail

the clinical use of curare, but a few remarks are in order.

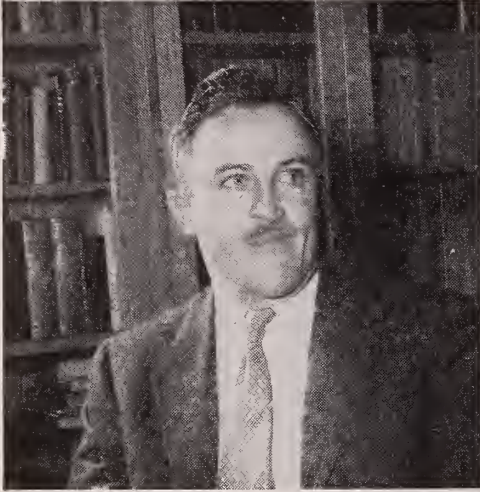
Relaxation of the muscles is often highly desirable in surgical procedures; it is not surprising, therefore, that the anesthetists have added curare to their armamentarium. Although curare has no anesthetic action *per se*, it has been found to serve as a useful adjuvant to certain anesthetic agents. It has been used also for the convulsions of strychnine poisoning, tetanus and hydrophobia, as well as certain spastic contractions. It could be of help in the management of dislocations, especially in heavily muscled individuals.

Curare should be employed only by experienced workers, for the muscles of respiration may become paralyzed and unless mechanical respiration be given immediately, the patient will die of asphyxia. Fortunately curare is quickly excreted by the body and the patient will soon start voluntary breathing movements.

In conclusion—let us return to the stories of Sir Arthur Conan Doyle. We must not criticize him harshly for taking certain liberties with curare in his novel, "A Study in Scarlet." A writer of fiction should be allowed certain privileges—a poetic license let us say. "The Sussex Vampire" could have been written only by an individual quite familiar with the action of curare and with a good understanding of clinical medicine. This story is of especial interest to physicians. Not only is curare used in the plot in an interesting and unusual manner, but certain psychosomatic problems are presented: The estrangement of the husband and wife, and a clear portrayal of how the mind may become warped in a physically handicapped youngster, even though he be reared in an excellent environment.

Indeed, the entire story is handled in a masterly fashion not only from the medical point of view, but from the humanistic as well. This is the sort of thing we would expect of Sir Arthur. We can well be proud that he was a member of our cherished profession.

New Appointments



PETER E. PRATT

Thomas H. Lanman, '16, Director of Alumni Relations of the Harvard Medical School, announces that the Council of the Harvard Medical Alumni Association has approved the appointment of Peter E. Pratt as Executive Secretary of the Association.

Mr. Pratt who has served as Secretary of the Harvard College Alumni Association since 1949 will bring to this new post his experience in alumni affairs and will aid in strengthening the ties between the Harvard Medical School and its 5,500 alumni throughout the country. He will begin his new duties this month, but will continue to serve the University-wide alumni office part-time until his successor there is named. Mr. Pratt will be available to help medical alumni groups in all parts of the United States, and will assist in keeping the alumni informed of developments in the School's activities.

This appointment does not represent a new departure in the organizational planning of the Alumni office. The Council has been aware of the need of this office in this respect for several years and for the past two years has been searching for the right man for the position. This search has

now culminated in the appointment of Mr. Pratt.

Mr. Pratt, who is secretary of the Harvard College class of 1940, served with a tank destroyer company of the Army in the European theatre during World War II. He was cited for gallantry in action at both Salerno and Anzio. A native of Milton, Massachusetts, he prepared for college at Milton Academy. He lives now at Charles River, Massachusetts.



GUSTAV J. DAMMIN, Professor of Pathology

Dr. Gustav J. Dammin has been appointed Professor of Pathology at the Harvard Medical School and Pathologist-in-Chief of the Peter Bent Brigham Hospital. He succeeds Clinton Van Zandt Hawn, '41, who has resigned for reasons of health.

Before coming to Harvard Dr. Dammin was Professor of Pathology and Chairman of the Department of Pathology, Washington University School of Medicine, and Director of the Laboratories of Pathology at Barnes Hospital, St. Louis.

During World War II, Dr. Dammin studied the control of dysentery, malaria,

filariasis and other tropical diseases as Commanding Officer of the Army's Puerto Rican Department Laboratory and as Executive Officer and Parasitologist of the Dysentery Commission in the India-Burma Theatre. In 1945-46, he was Director of the Laboratories Division, Office of the Surgeon General, and since then he has been a consultant to the Surgeon General. He also is adviser to the Civil Defense Administration.

Since the war, Dr. Dammin has made studies especially of the effect of tuberculosis and other lung infections of the heart and blood vessels.

A native of New York, Dr. Dammin was graduated from Cornell University in 1934 and received the M.D. degree from Cornell Medical School in 1938. He also studied tropical medicine in the University of Havana. He interned at the Johns Hopkins Hospital and, in 1940, was assistant resident in medicine at the Peter Bent Brigham Hospital.

The appointment of Dr. Charles S. Davidson as Associate Professor of Medicine in Harvard University has been announced.

Dr. Davidson has resigned as Chief of Clinical Research of the National Institute of Arthritis and Metabolic Diseases in order to accept this position. He is a member of the Commission on Liver Disease of the Armed Forces Epidemiological Board and a member of the Council of Foods and Nutrition of the American Medical Association. He is chairman of a committee on low sodium foods of the National Research Council.

Dr. Davidson has served on the staff of the Harvard Medical School and on the staff of the Thorndike Memorial Laboratory of the Boston City Hospital since 1941. He will continue as Associate Physician at the Thorndike Memorial Laboratory. A native of Berkeley, California, he was graduated from the University of California in 1934, and received the M.D. degree from McGill University in 1939.



CHARLES S. DAVIDSON
Associate Professor of Medicine

Honors



Oxford Mail

DR. A. L. POOLE (President of St. John's) and
DR. A. BAIRD HASTINGS who received a D.Sc.
degree from Oxford University recently.



Dr. Berry's Christmas Card

Many Harvard Medical Alumni had their first glimpse of an attractive dry point etching of the Administration Building when their Christmas mail brought greetings from the Dean. After searching for a good pictorial reproduction of the School, Dr. Berry by chance saw a copy of the original etching in the home of a friend.

Inquiries revealed that this etching had a pleasant Harvard story behind it. Mrs. Elizabeth Verner, of Charleston, its creator, came to Boston several years ago for medical treatment. As she became acquainted with the sights of Boston she was struck by the imposing classical lines of the Harvard Medical School buildings. Discussing their pictorial potential with her friend Dr. J. Warren White, '17, he took her to the top of the Boston Lying-in Hospital where she could get a full view of the School. From there the original sketch was drawn from which the etching was made.

Mrs. Verner is no amateur artist. Her etchings of Charleston, particularly, and of other regions which have attracted her eye are well known to collectors. She has made sketches in England and France and all over the continent. She made eighteen pencil drawings of New York City, drawings which were bought for Rockefeller Center. And in 1937 she brought back twelve etchings from Japan, a group which is now being exhibited throughout the country. The Japanese etchings, together with a group of etchings of Charleston, have just been shown at

Doll & Richards in Boston, where Alice Lawton commented that they were "not only excellent as to technique and truly decorative, but rich in the warm feeling and understanding that underlies all true art." Her work is currently being shown at the Norfolk Museum of Arts and Sciences and at the High Museum in Atlanta. There is a collection of Elizabeth O'Neill Verner's work, complete through 1937, in the Metropolitan Museum. Thirty-five of her etchings are in the Congressional Library, placed there by the South Carolina Daughters of the American Revolution. There is a large collection in the Hispanic Museum in New York, and she is represented in the permanent collections of innumerable museums, such as the Boston Museum of Art, the Chicago Art Institute, the National Gallery of Washington, and many others.

With her permission the School's Christmas card was made. Inquiries have been received asking if copies suitable for framing were available. Reproduction and mailing costs have been explored. Preliminary figures suggest that for a price of approximately \$5.00 a 13½" x 9¾" print may be obtained.

Before proceeding further, the Association wishes information about the demand for prints of this nature and size. If the demand warrants, the Association will arrange to have them made available.

Interested alumni should write to the Secretary, the Harvard Medical Alumni Association, 25 Shattuck Street, Boston 15, for further information.

*A Contribution to the Alumni Fund**

FORBES H. NORRIS, JR., '55

I am enclosing a cheque as the first contribution to the Alumni Fund from the Class of 1955. The reason I am able to send this cheque has a story that may be of interest and perhaps shows, also, an unusual way by which a medical student may help to finance his education.

In Harvard College I had enjoyed considerable success as an amateur swimmer. When I came to the Medical School, in hopes of lessening the costs of medical school life, I determined to give up my amateur standing as an athlete and I became a professional swimmer, gave lessons in swimming and diving to young people and competed in the ten-mile race for \$10,000 and the World Championship at the Canadian National Exhibition, Toronto. In 1951, I was fifth in this race. This year, by dint of training twice as hard, I finished second and won over \$2500.

We had a marvelous race on August 19th, racing up and down over the half-mile course on Lake Ontario in front of Toronto between the grandstand and the breakwater at the Exhibition grounds. The temperature in this part of the lake was about 65 degrees and over a hundred thousand persons attended the Exhibition. Among the entrants in the race were the first five place-winners in 1951, four former winners, the national champion of Sweden, and a team of four Egyptians. These were the same men who swam the English Channel a year ago, and then refused the prize put up by the *Daily Mail* because the money was British!

One has to see the race to believe it. When I first competed I went to Toronto expecting a ten-mile *swim*, not a ten-mile *race*. Having learned my lesson, I trained much harder this time, averaging five

miles of swimming in my daily training sessions, and going to Canada before the race to wind up my training with a week of fighting the waves on Lake Ontario. This also gave me a chance to meet the lamprey—an unpleasant eel about a foot long. I picked up—or rather, I was assaulted by—three in one practice swim. Fortunately, none bothered us in the race. It was flattering to be mistaken for a fish until I found that these eels will attack almost anything moving in water, including small boats. The trick in dealing with them when one gets hold of you is to control your first impulse to leap right out of the water, and then grasp it about the gills, pull it loose, and throw it away. It won't come at you a second time unless you fail to throw it far enough. Actually, the eels were less of a worry than the mononucleosis bugs, which felled me after my first month of hard training. Dr. Arlie Bock advised, "Lay low for awhile," and the infection passed off in a few days.

While in Ontario before the race, I became great friends with Clifford Lumsden, of New Toronto, who had won the race twice before. We decided the best chance for one of us to win lay in going out very fast from the start and putting enough pressure on last year's winner, Jerry Kerschner of Toronto and Columbus, Ohio and on George Bevan of Winnipeg, who finished second, to make them drop out. In 1951 they had gone out in the beginning so fast that no one else had a chance to get into the act until too late to catch either; they were together for nine miles, but Bevan failed at the end and Kerschner won. We had our job cut out for us, as Kerschner used to hold a world record in sprinting and Bevan had been Canada's fastest sprinter.

The end of the first mile saw us all abreast, with Bevan edging ahead to win the lap prize. We swam furiously down

*A letter to Dean Berry and to Dr. Thomas Lanman. It is published in the BULLETIN with the consent of the writer and of Doctors Berry and Lanman.



The Globe and Mail, Toronto

AT THE FINISH:

Left: Referee ERNST VIERKOTTER. Representing Germany, won the first race in 1927, 21 miles for \$25,000.

Center: 1952 winner CLIFFORD LUMSDEN, of New Toronto, Ontario, also won in 1949 and 1950.

Right: 1952 runner-up, Forbes Norris, author of this article, of Winchester, Mass.

the course and back again, and this time Kerschner was leading. In the third mile, once more we all swam abreast for nearly the full way, looking like a "water ballet" team except none of us was worrying about the aesthetics of the situation. I was beginning to wonder how long we could keep up such a pace. At the end of the fourth mile, I took the lead; in the fifth mile, Kerschner and Bevan cracked and fell back. Cliff and I, swimming abreast, finished five miles several minutes under the record for that distance; we carried on together until the eighth mile, when he showed his true strength and pulled away from me, finally winning by over two hundred yards in four hours, twenty-six minutes, thirteen seconds. Kerschner and

Bevan, in the meantime, had been fished out of the water, third place going to Steve Wozniak, of Buffalo, a former winner, and fourth to Tom Park, of Hamilton, Ontario. The Egyptians, Hassan Abou Bakr, Saied El Araby, and Abdel Latif Abou Heif, placed fifth, sixth, and seventh, and the Swede, Lars-Bertil Warle, was eighth.

If I couldn't win, I'm glad that Lumsden did. Next year, I want to train twice as hard; if he increases his own workouts, we ought to have an even better race.

Swimming in water of that temperature and for so long a time has a definitely chilling effect. In my case, post-race treatment consisted of a nap in a hot bath, followed by a hot meal and a good rest!

Harvard Medical Alumni Fund

PROGRESS REPORT

JULY 15, 1952—JANUARY 15, 1953

Class	Agent	Living Members	Givers	Percent Participation	Amount
1878-1900		181	35	19.3	\$461.
1901	Horace Binney	39	12	30.7	338.
1902	George W. Winchester	47	11	23.4	306.
1903	John Homans	49	8	16.3	225.
1904	J. Dellinger Barney	55	24	43.5	458.
1905	Nathaniel W. Faxon	27	5	18.5	102.
1906	Horace P. Stevens	36	11	30.6	227.
1907	James B. Ayer	31	1	3.2	25.
1908	George G. Smith	31	13	42.	295.
1909	Reginald Fitz	30	7	23.3	153.
1910	Alex M. Burgess	40	3	7.5	30.
1911	J. Howard Means*	56	12	21.4	585.
1912	Francis M. Rackemann	40	14	35.	510.
1913	George P. Denny	43	16	37.2	665.
1914	W. Richard Ohler*	57	19	33.3	735.
1915	Arlie V. Bock	65	18	27.7	660.
1916	Thomas R. Goethals*	50	14	28.	930.
1917	Leroy E. Parkins	51	3	5.9	150.
1918	Donald S. King	63	20	31.7	1,155.
1919	Joseph Garland*	78	28	35.9	960.
1920	Charles C. Lund	79	25	31.6	990.
1921	William B. Castle*	83	22	26.5	1,515.
1922	G. Colket Caner	90	21	23.3	1,710.
1923	Robert Goodale	105	38	36.2	1,745.
1924	George C. Prather	111	26	23.4	1,475.
1925	Richard B. Cattell*	107	34	31.8	2,015.
1926	Gilson C. Engel*	117	44	37.6	2,003.
1927	Charles J. E. Kickham	121	21	17.3	765.
1928	Myles Baker*	116	35	30.2	6,366.08
1929	Herbert E. Hedberg	120	36	30.	4,070.16
1930	Alfred O. Ludwig	132	42	31.8	3,665.
1931	John A. Abbott	124	43	34.7	1,495.
	Charles H. Bradford				
1932	Carl W. Walter	126	33	26.2	3,210.
1933	J. Englebert Dunphy*	122	54	44.3	3,344.
1934	Richard Warren	128	28	21.9	1,818.
1935	George P. Whitelaw*	130	24	18.5	1,268.
1936	Howard Ulfelder	130	51	39.3	1,730.
1937	Joseph R. Frothingham*	134	37	27.6	1,458.
1938	Irad B. Hardy, Jr.	131	37	28.2	1,320.
1939	Daniel S. Ellis*	126	9	7.1	195.

Class	Agent	Living Members	Givers	Percent Participation	Amount
1940	W. Benjamin Bacon*	132	69	52.1	3,812.
1941	Curtis Prout*	131	43	32.8	1,676.
1942	Oglesby Paul*	128	55	43.	840.
1943A	James H. Jackson*	141	50	35.5	1,206.
1943B	Harrison Black*	130	50	38.4	854.81
1944	Robert W. Taylor, Jr.	141	41	29.1	574.50
1945	Robert S. Shaw	138	45	32.6	410.
1946	Milton W. Hamolsky	142	46	32.4	331.50
1947	Hermes C. Grillo	127	53	41.7	358.
1948	Curtland C. Brown	137	37	27.	251.
1949	John W. Keller	141	38	26.9	291.
1950	Henry Minot, Jr.	133	23	17.3	147.75
1951	Edward G. Dreyfus	146	31	21.2	140.75
1952	James A. Pittman, Jr.	139	25	17.9	82.

CLASS TOTALS	5,307	1,540		\$62,102.55
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CONTRIBUTIONS FROM FRIENDS		2		305.
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TOTAL		1,542		\$62,407.55
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*with Fund Committee

Second Annual Drive ends June 30, 1953

Remember These Dates

**ALUMNI DAY AND REUNION DINNERS
THURSDAY, MAY 28**

**CLASS DAY
FRIDAY, MAY 29**

**ANNUAL DINNER
WEDNESDAY, JUNE 3
(New York City)**

Harvard Medical Society Meeting

The October meeting of the Harvard Medical Society was held in the Bigelow Amphitheatre of the Massachusetts General Hospital. The program was sponsored by the Department of Surgery of the Hospital, Dr. Edward D. Churchill presiding.

Metabolic Rate and Thyroid Function Following Acute Thermal Trauma in Man

George L. Nardi, Richard L. Rovit
and Manuel Quijano

The widespread and severe destruction of body tissue seen following burns is reminiscent of that observed in advanced hyperthyroidism. While possibly a function primarily of the alarm reaction, the question arises whether the thyroid itself may not play a role in this phenomenon. Study of thyroid activity in 12 severely burned (20-60% of body surface) patients revealed universally elevated BMR's, occasionally in the range of 80 or 90, which pursued a slow return to normal over the course of several months. Completion of healing usually coincided with reattainment of normal BMR. In 4 patients with only moderate burns (15-20%), small elevations in BMR were found to subside rapidly.

For comparison, observations were made in 6 patients undergoing surgical procedures, and 6 with perforated ulcers receiving fluid therapy similar to that of burned patients. None of these individuals had a history of previous thyroid dysfunction. Their BMR's paralleled those of the moderately burned patients, except in the case of the perforated ulcers, where more striking elevations were noted. These, however, fell rapidly to normal. In one healthy volunteer maintained on the high calorie, high protein diet given to those with burns, no alterations in BMR were noted.

Whether the responsible agent for these metabolic changes is thyroid hormone was settled in the negative by the constant observation of normal PBI and radioactive iodine uptake in all patients in the study. Fever must be discounted as of little importance, since poor correlation was found

between temperature chart and BMR elevation. Similarly, the specific dynamic action of protein appears an unlikely causative factor in view of the negative results in the normal volunteer and the restoration of BMR to normal when patient's intake is the greatest. Adrenal cortical hyperfunction also seems a doubtful answer, in that the BMR is usually below normal in Cushing's syndrome, and is at best normal in ACTH-treated arthritics. The evidence points to the intense local metabolism of the burn wound itself as responsible for the changes observed.

The Ebb and Flood of the Eosinophiles in the Burned Patient and Their Use in Clinical Management

Anne Wight, John W. Raker and
William R. Merrington

Observation of the pattern of changes of eosinophile counts in 31 patients with burns of varying degrees of severity has been found to be of considerable value in their management and prognosis. Immediately following the burn, a drop in eosinophiles, often below $5/\text{mm}^3$, is noted. While affording evidence of the integrity of the adrenal cortex, this observation has no further prognostic significance. In severely burned patients making satisfactory clinical progress the count begins to rise on or before the third day after the burn, and by the sixth week assumes flood proportions, of the magnitude of 400 to 2,000. This high tide persists for weeks to months, returning to normal levels with wound healing. It is not part of a generalized leucocytosis nor is it associated with signs of adrenal insufficiency.

Failure of the eosinophiles to rise on or before the third day is of ominous import. This was demonstrated in 8 patients, all of whom had counts remaining below 33. All eight died. (If ACTH or cortisone was given directly following the burn, postponement but not prevention of the rise was observed). Persistence of a subnormal or normal count during the second or third

month after an extensive burn is noted in patients who do poorly. Transient secondary falls are expected after debridement and skin grafting but if the count remains low it suggests that the patient is already burdened and will tolerate poorly any additional operative stress.

Adrenal Hormones and Increased Capillary Permeability of Burns

An Experimental Evaluation

Anne Wight, Philip Weisman and
Richard L. Rovit

The statement has been made that ACTH and cortisone lessen capillary permeability, and in consequence can prevent plasma losses in burned patients. To test the validity of this assertion, burns were produced in anesthetized dogs by immersing their feet in water at 90°C for 10 seconds. Volume of edema was measured by plethysmograph. Lymph flow and protein concentration were determined after lymphatic cannulation. In addition, attention was given the accompanying changes in serum protein and hematocrit. The customary alterations in these dimensions produced by the burn were in no way modified by administration of the hormones, indicating that no limitation in protein or fluid requirements can be expected from their use in the burned patient.

Observations on the Conditions Governing the Emptying of the Stomach in Man

William R. Waddell and C. C. Wang

The influence of fat on gastric behavior has long engaged students of the physiology of digestion. In 1896 Ewald and Boas observed that olive oil inhibited gastric secretion and delayed evacuation. For many years these phenomena were considered to result from reflexes initiated by contact of fat with intestinal mucosa but the researches of Robbins and Boyd (1923) and Farrell and Ivy (1926) indicated that nervous mechanisms were not necessary and firmly established, that humoral mechanisms were important. The relative importance of reflex and humoral factors remains unsettled.

This study utilized the techniques of fluoroscopic observation and x-ray film recording of rates of gastric evacuation after high-fat meals made up of 80 grams of emulsified fat mixed with barium sulfate in a volume of 260 cc.

Ten normal subjects served as controls and they evacuated the meals slowly requiring more than four hours for complete emptying. Five patients with gastroenterostomy behaved similarly, evacuation being only slightly accelerated. The emptying in 14 patients with subtotal gastrectomy and gastroenterostomy was exceedingly rapid. Another group of 16 patients with vagotomy and gastroenterostomy emptied at equally fast rates. The most likely explanation of the elimination of the retentive capacity of the stomach by resection of the distal portion or by vagisection is that nervous mechanisms are responsible. If humoral agents are of importance their liberation and/or effect is dependent upon intact parasympathetic pathways.

In the discussion that ensued the suggestion was made that in creating autotransplants of the stomach postganglionic section might cause unusual sensitivity to cholinergic substances.

Metabolic Changes Associated with Eck Fistula in Man

William V. McDermott, Jr.

Of great interest are the observations made in what is probably the first case of an Eck Fistula in man without collateral venous channels due to portal hypertension. The rearrangement of vascular channels was accomplished by anastomosing the superior mesenteric vein to the Vena Cava, for the purpose of resecting the portal vein in a patient with carcinoma of the pancreas. The patient was discharged feeling well after 19 days, and readmitted one month later for study. At this time carbohydrate metabolism was not remarkable. A diabetic trend noted in the oral glucose tolerance curve was ascribed to the absence of the buffering action of the liver, and I.V. glucose tolerance proved to be normal. Serum van den Bergh had returned to

normal, while urine and stool urobilinogen reached very low levels. That this was not evidence of obstruction but rather of deficiency in synthesis, was demonstrated by a normal alkaline phosphatase. Relatively low normal plasma protein was observed, with the A/G ratio undisturbed. However, clearance of iodinated human plasma was subnormal, and the low normal protein was evidently maintained with difficulty. Finally, prothombin time was depressed to 45%, without bleeding tendencies, and no response was obtained to hykinone.

Two months postoperatively, the patient was admitted in a stuporous, semi-comatose state, from which he recovered in 48 hours. Renal function tests disclosed nothing of significance, while his hepatic status had remained unchanged. The episode was ascribed to a cerebro-vascular accident, but after recurring twice again reinvestigation was made with the hope of uncovering some previously unrecognized metabolic defect. In dogs with Eck Fistulae, a state of 'meat intoxication' had been observed, which was reminiscent of the patient's attacks. Pursuing this hint, he was placed on a high protein diet, and in a few days there followed an episode of coma lasting 48 hours. Many studies were made during the high protein feedings, but no abnormalities discovered. Approaching the problem from a different tack, the patient was next fed 180 gms. of urea for two days, and promptly went into a very deep coma lasting 5 days. BUN at this time was increased, but never to levels which might conceivably cause symptoms.

The issue was finally resolved by turning to measurement of blood ammonia. Resting blood showed higher ammonia N than normal (50 gamma %), and following urea a marked rise (to almost 600 gamma %) was manifest, accompanied clinically by confusion and disorientation. Identical results followed oral ingestion of ammonium chloride or ion exchange resin containing 75% ammonium. Surprisingly, blood ammonia returned to normal directly after feeding was stopped, while the clinical neurological status progressed inex-

orably. These observations would seem to correlate with the production of hepatic coma by ammonium administration. Normally, ammonia is synthesized to urea in the liver; what effect it may have on enzyme systems in the brain when its usual metabolic pathways are interrupted is yet to be determined.

Our Experience with 34 Cases of Cushing's Disease

John W. Raker and Oliver Cope

Dr. Raker reviewed the experience of the MGH group in the care of 34 patients with Cushing's syndrome. Experience with these patients has shown that a therapeutic attack upon the adrenal cortex is the most successful in alleviating this condition. Eight of the patients had benign adenomas of the adrenal cortex, 5 had adrenal cortical carcinomas and in 21 instances the adrenal cortices were found to be hyperplastic. Total surgical extirpation of a functioning tumor or subtotal surgical removal of hyperplastic adrenal cortical tissue has been followed by dramatic improvement in many of these patients.

Severe nutritional depletion and increased incidence of bacterial infections complicate the handling of these patients. At the time of surgical exploration the surgeon learns to distinguish the pathological process in the adrenal cortex by its gross appearance: a functioning tumor of the adrenal cortex is associated with atrophy of the remaining cortex and the hyperplastic cortex is recognized by its characteristic increased thickness and the whorl-like appearance of its surface.

Post operative management of these patients may require skilled judgment, for they may develop adrenal cortical insufficiency. Even with the support of cortisone therapy they may present serious problems in the repair of nutritional deficiencies. Ultimately most of them do not require continued hormonal medication; but maximum improvement may not be reached before 6 to 8 months have passed.

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Harvard Medical School
Boston 15, MassachusettsTHE MEDICAL SCHOOL AND THE
AFFILIATED ARMY HOSPITAL

At a recent meeting of the Faculty it was voted to "reactivate on paper" the Harvard affiliated unit, known in World War I as Base Hospital # 5 and in World War II as the 5th General Hospital. Similar action has been taken by the Massachusetts General Hospital and the Boston City Hospital with respect to Units 6 and 7. The Peter Bent Brigham Hospital has voted to support The 5th General Hospital in cooperation with the Medical School. This action is in contrast to a refusal to sponsor affiliated units by these same organizations when requested to do so by the Surgeon General shortly after World War II. The reasons for the change in attitude and the current approach which has been made by the Surgeon General are of interest to the Alumni.

It is well known that the experience of many affiliated units in World War II was not a happy one. The call of most units to active duty was followed by long periods of wasteful inactivity. Faulty staffing led to over-crowding with top flight

individuals, blocking of promotions and the necessary delegation of what might have been key personnel to comparatively menial administrative tasks in which their talents and ability as surgeons or physicians were totally lost. Finally, in most instances the personnel of the affiliated units held reserve commissions and following discharge many of them were subject to a barrage of annoying and even derogatory mail for their failure to attend meetings and participate in other reserve activities, the bulk of which was sponsored and planned by other than medical officers. As a consequence of these experiences not a few medical officers who served in affiliated units in World War II vowed never to be caught in that situation again.

On the other hand, the tradition of the affiliated units is a worthy and patriotic one. Conceived by George Crile, Sr. and modeled on lines which he drew from his hospital experiences in working with the British during the early days of World War I, the affiliated units had the vigorous and wholehearted support of the best medical and surgical minds of that day. There were unhappy experiences in some of those units, but when World War II developed, it did not dampen the enthusiastic support given to the affiliated units and the Armed Services by such men as Ravdin, Pinkus, Cutler, Middleton, Bauer, Churchill, and countless others. Moreover, the records of the affiliated units, with a few unfortunate exceptions, have been most distinguished in both World Wars.

The 5th General Hospital was among the first units called to active duty in each war. In World War I it was the first to arrive in France and the first American unit of any type to suffer casualties at the hands of the enemy. In World War II it was the first general hospital to enter the European Theatre and was the first to function under canvas on the Normandy beach-head. More than half of the men listed in the original roster of officers of the Harvard Unit were promoted to positions of great responsibility either as Consultants or Chiefs of Service in other hospitals.

The Chiefs of Service of many other hospitals and the Consultants throughout all theatres of the war were in large part recruited from the original staffs of the affiliated units. It was extremely valuable for these men to have seen at first hand how a well staffed unit functions prior to taking over their larger responsibilities.

The Surgeon General, in an effort to preserve the traditions of the affiliated unit and to furnish what could be counted upon as first class hospitals in the event of another emergency, has made a new approach to the Medical School. He has proposed that the Medical School and the Office of the Surgeon General mutually agree that on D-Day plus one year the Medical School furnish the key personnel, namely, the Chiefs of Service and of Sections for a General Hospital. The Surgeon General in turn will furnish the remainder of the personnel and will arrange to have the unit assigned to active duty simultaneously or prior to the arrival of the professional personnel. The members of the unit need not be assigned by name and no reserve commissions will be given. This arrangement allows the School great flexibility in the selection of men for the unit. It guarantees that the professional personnel will not be activated for long periods of time prior to the actual functioning of the unit. To be sure, some type of indoctrination course will be necessary, but the long "training programs" of World War II will be avoided. Finally, from the point of view of the individual officer, it is a unique advantage to be assigned to a unit without the distinct disadvantages of having to accept a reserve commission. On the other hand being designated as a member of the unit will not make an individual immune to a call to active duty through the doctor-draft law.

In summary then, this new arrangement will preserve the traditions of the affiliated units, assure the Surgeon General of first rate general hospitals and permit the University Medical Schools to plan in a realistic way for a possible emergency.

It is unfortunate that this sort of gentlemen's agreement between the Surgeon

General and the Medical School is necessary. It is evident, however, that the Surgeon General does not yet have the command authority necessary to allow him to make agreements with the Medical School which involve reserve commissions and at the same time exert complete control over the personnel involved. It is to be hoped that with future developments, the relationship between the Medical Reserve and the Office of the Surgeon General will become a direct chain of command rather than an optimistic liaison.

Correspondence

To the Editor:

It is with heavy heart and only at the insistence of several classmates that I take up my pen to correct an impression which might lie in the minds of readers of the *ALUMNI BULLETIN* following the recent publication of Dr. Rolf Lium's letter concerning Dr. Kendall Emerson's speech on "How to Get Your Son into the Harvard Medical School." The uninformed reader of Dr. Lium's missive would be led to the conclusion that the Class of '33 was distinguished by its irresponsibility, lack of decorum, and disrespect for constituted authority. Dr. Lium mentioned specific instances in support of this point of view and by innuendo implied that many others could be described. The fact of the matter is, that no class in the Harvard Medical School individually or collectively has been more distinguished for its propriety, sobriety, probity, and rectitude. No group containing men of the calibre of Crile, Bushnell, Trommald, Corbus, and Dunphy could possibly be imagined to be otherwise.

I am sure all members of the Class of '33 share my sadness at this premature decay of a once fine mind. No other explanation can be imagined for these figments of Dr. Lium's imagination. Is this the man whose eloquence from the pulpit once thrilled the late Calvin Coolidge? Is this the sober scholar that once charmed his classmates by his brilliance and industry? Alas, no.

T. B. QUIGLEY, '33

* * * *

To the Editor:

Though I suspect the tongue in the cheek of Dr. Quentin T. Hardy in the last issue of the *BULLETIN*, he is to be commended for a consistent and rational solution of the parking problem in the Automotive Age—consistent, that is, with

the fact that beauty has become obsolete in all the so-called fine arts—architecture, music, painting, sculpture, poetry. The Medical School Quadrangle transformed into a concrete desert and packed full of cars would represent “functionalism” at its best and would go far to atone for the antiquated classicism of the surrounding buildings.

The parking problem at the Medical School is no more baffling there than it is everywhere; but Dr. Hardy's solution can bring equal relief in other parts of Boston. Turn Boston Common into a vast parking lot for 10,000 cars (without the expense of subterranean construction) and the traffic problems of the shopping and business districts will vanish.

Dr. Hardy has got something! *Magna est utilitas et praevalabit.*

But until the dawn of a better day, how about a three-cent stamp to carry his check to the Alumni Fund?

“MOSSBACK”

To the Author of the “Stethescope”:

As a graduate of Harvard College 1905 and of the Harvard Medical School 1909, I wish to add my protest to that of an Eli against the felonious spelling of Stethescope instead of Stethoscope in the Medical Alumni BULLETIN. With wrath and scorn I am,

Your classmate,

HAROLD T. BOWDITCH, '09

P. S.—I noticed it long ago, but was too polite—or too lazy—to mention it.

To the Editor:

The reason for this, my first letter to the BULLETIN, is ostensibly to contribute to the controversy concerning the spelling of the word “stetho(e)scope,” but actually might be also to point out how carefully I read the BULLETIN, even the fine print in the “Correspondence” section, where the said controversy was brought to my attention. This fine print reading was acquired in Anatomy, after a section man stumped me on a question from the fine print in Gray.

I also believe that the word should be “stethoscope,” and I offer myself as the necessary Harvard Medical alumnus educated at Harvard (A.B., '40), called for in the Editor's comment.

The controversy may continue to rage, however, since all my *classical* education was acquired at Phillips Exeter Academy, where I did *not* study Greek.

HARRY F. HINCKLEY, JR., '45

To the Editor:

Many thanks for your courteous reply to my letter *in re* the misspelling, “StethEScope,” and explanation of its origin. It was particularly interesting to learn that the error apparently originated with one of my revered former teachers, Dr. Reginald Fitz, and that he had already been

called about it some fifteen years ago. The continuation of such conservatism is to be decried. Now is the time for all good etymologists to rush to the aid of the BULLETIN. Let the printers be encouraged to set up the letter “o”!

ALEXANDER T. BUNTS, '24

To the Editor:

My indignation naturally knew no bounds when I saw the unauthorized use of my name in your Correspondence column, 26:45, April, 1952, regarding parking problems at the Medical School. Had I had any intention of writing “to the editor,” which I had not, I would not have done it—in fact, I think none but congenial idiots use this method of getting their names in print. Had I done it, however, it would certainly not have been for the purpose of promoting any such absurd scheme as that which was foisted on you, apparently over a forged signature. I hope that this prankster will not go so far again.

This protest, however, is not my main reason for writing. A worthier subject for consideration was suggested to me by the controversy in the same issue over the spelling of “stethescope,” as the word is used for a department heading in your publication. I have a better idea—that instead of merely correcting its spelling, the title “Stethescope” be abandoned altogether in favor of “Tidal Drainage.” This has an affinity with, but by no means imitates “The College Pump,” which appears more or less irregularly in the regular *Harvard Alumni Bulletin*.

This seems to me for various other reasons to be an almost perfect title for that section of your BULLETIN. It reminds one of the location of the Medical School, between Muddy River and the Back Bay. It suggests also the periodic rapid emptying and slow refilling of certain minds every time the BULLETIN is published.

QUENTIN T. HARDY, '19

NEEDED

As a Faculty member of the Vanderbilt Hall Committee my attention has been drawn to the appalling condition of the half dozen pianos in the common room and music practice room of the building. These were in excellent condition when the building was opened in 1928 but most of them are now literally worn out.

A surprising number of medical students are better-than-average musicians. At the present time there is hardly a piano in Vanderbilt Hall worthy of their efforts. It occurred to the Committee that among the alumni there may be a few who own pianos in good condition for which they have no further use. If such is the case a communication to the undersigned would result in the prompt removal of the piano at no expense to the alumnus involved and the fulfilling of a definite need.

T. B. QUIGLEY, '33

Book Reviews

MODERN ELECTROCARDIOGRAPHY, Vol 1. By Eugene Lepeschkin, M.D. 600 pages. Baltimore: Williams and Wilkins Company, 1951. Price \$12.00.

This is Volume I of a work on electrocardiography and deals with abnormalities of the auricular and ventricular complex in the regularly beating heart. If for no other reason than the completeness of its bibliography of 10,000 references, this is, particularly to workers in the field, a most welcome addition to the literature. The author reads, "in descending order," the following languages: Russian, English, German, Spanish, Italian, French, Portuguese, Czechoslovakian, Dutch, Swedish, Roumanian and Bulgarian. This work is encyclopedic in scope and authoritative in presentation but not for the beginner.

The disheartening experience of the author with the manuscript is of interest. While en route to the publishers to discuss details as to publication he parked his motor car for about 45 minutes in New York City. When he returned he found that the front window of the car was broken and all contents including the first draft of the manuscript, with interleafed additions and bibliography, were stolen. Having deferred the final typing of the book until all additions were completed, he had inserted each new note in its place in the manuscript without making new notes about it. In preparing a new manuscript he had to start from the beginning including a re-reading of all available journals as far back as 1939. It was easier to write the book for the second time, but it took him two years to complete it. This volume stands as a testimony of the tenacity of the author and well deserves a place in every medical and cardiological library.

HAROLD D. LEVINE, '32

PHARMACOLOGY IN CLINICAL PRACTICE. By Harry Beckman, M.D. 832 pages. W. B. Saunders Company, Philadelphia and London, 1952. Price \$12.50.

This book represents a new departure from the usual method of presenting pharmacological data and reflects the opinion and experience of Dr. Beckman, gained in over 20 years, in dealing with the subject. It consists of 2 sections, the first devoted to the clinical use of drugs and the second being a reasonably complete compilation of drug data much as is seen in the Merck Index or the United States Dispensatory.

The material presented in Section 1, which is the readable and most important part of the book, is divided into 15 subheadings consisting of

such subjects as allergy, anesthesiology, antibiotics, cardiology, dentistry, internal medicine, neuro-psychiatry, etc.

The practitioner of medicine will find the organization of this section useful when he is seeking a quick reference to the drug therapy of a disease. As in *Treatment in General Practice*, there is a paragraph or two describing, in a highly condensed manner, the disease. For the most part, these descriptions are so brief as to be nearly valueless. They are followed by listings and brief descriptions of the agents of value in treatment. Unfortunately, however, there is usually insufficient information given to enable the physician to wisely select the best agent available. Frequently the author has not helped since he has not made definite recommendations as to which is the better agent to use.

Section 11 is useful as a tabulation of information concerning drugs, but again, there has been no selection to guide the reader as to the author's preference among the many available products of any one preparation.

It seems to this reviewer that those wanting detailed pharmacological information will find the book unsatisfactory, and those seeking clinical guidance in the use of drugs will also find it lacking. It will, however, prove useful to those physicians who want a quick reference as to what agents are available for use in the treatment of a diseased condition.

DALE G. FRIEND, '35

NUTRITION AND DIET IN HEALTH AND DISEASE (Sixth Edition). By James S. McClester, M.D. and William J. Darby, M.D. 710 pages with 14 figures and 145 tables. Philadelphia & London: W. B. Saunders Company, 1952. Price \$10.00.

This recent edition of a standard text on nutrition and its application in health and disease is a great improvement. In the opinion of the reviewer it is the best book available in nutrition for the student of medicine or health. Part I deals with Nutrition in Health under subheads of The Need for Food and Its Utilization; Food Products, and Diet in Health. Part II is concerned with Nutrition in Disease and consists of 18 separate chapters. An appendix contains a number of useful tables including desirable weights and the composition of various foods and alcoholic beverages. Some references are given at the end of most chapters. The book is well presented. Like every other text in medicine and health the book abounds in statements that are opinions rather than facts, but if opinions were left out there would not be enough left to have a book. The book is highly recommended for medical students, health workers and physicians.

FREDERICK J. STARE, M.D.

William Thomas Salter

1901-1952



William Thomas Salter, physician, biochemist and pharmacologist, entered this world in Boston on December 19, 1901, and got his secondary schooling at that fine old academy, the Roxbury Latin School. In 1935 he married Eleanor Vallandingham, who survives him, together with three daughters.

From start to finish a good New Englander, Salter took his A.B. from Harvard in 1922 and his M.D. in 1925. That he made Phi Beta Kappa in college and Alpha Omega Alpha in medical school is evidence of the early excellence of his scholarship. That these achievements accurately presaged a distinguished career is confirmed by his receipt in 1941 both of an honorary A.M. from Yale, and more particularly of her chair of pharmacology with headship of that department.

Salter's medical internship and residency were at the Massachusetts General Hos-

pital (1925-27 and 1927-28). After that he had a year in London as Mosely Travelling Fellow of Harvard (1928-29) working in the laboratory of Professor Charles R. Harington. On returning from this experience he continued to serve his alma mater in posts of increasing responsibility.

For ten years (1929-39) he held the post of Tutor in Biochemical Sciences at Harvard College, a distinguished and unusual job for a doctor of medicine. During this same decade he rose from research fellow to Assistant Professor of Medicine in the Faculty of Medicine, and served as a member of the Cancer Commission of the University. Parallel hospital appointments included those of Associate Physician, first at the Huntington Hospital of Harvard, and then at the Thorndike Memorial of the Boston City Hospital. His final flowering, prematurely cut short by his untimely death, was in his last decade at Yale.

The writer first met "Bill" Salter at Woods Hole during his medical student days. It was quite evident even then that he had a deep interest in, and sound grasp of, biochemistry. However, he wanted to apply this fundamental discipline to clinical medicine, and that led to his hospital career. Salter's career exemplified indeed to an unusual degree the fusion of basic science and medical practice.

His exposure to Harington, the synthesizer of thyroxine, set the direction and pattern of his investigative career. Throughout the remainder of his life he was concerned with the thyroid hormone, its structure, its biosynthesis and metabolism, and the relation of the structure of its molecule to its physiologic activity. He made expert use of the new methods as they came along, radioactive iodine, chromatography, and all the biochemical and biological methods applicable to his field.

His investigative work was reported, of course, steadily as he went along at scientific meetings and in scientific journals, but it was brilliantly assembled and integrated in his monograph published in 1940 entitled, "The Endocrine Function of Iodine." He was planning shortly before his death to bring this work up to date in the form of a second edition. He received in April 1949 the Iodine Award for 1948 of the American Pharmaceutical Association—"For outstanding research in the pharmacy and chemistry of Iodine including fundamental pharmacological and clinical investigation relating to the function of iodine in nutrition and its role in metabolism."

Salter was not only a born investigator, but also a willing and inspiring teacher. The effectiveness of his teaching was enhanced by a puckish sense of humor. As was the Iodine monograph an expression of his love of research, so was the massive textbook of pharmacology which appeared just before his death an earnest of his devotion to education. Who can doubt that the vast labor which went into the preparation of this volume was contributory to his death.

For his drolleries as well as for his flashes of genius, but above all for his capacity for friendship, one loved Bill Salter. To visit his laboratory was a refreshing intellectual bath. To go through Woods Hole with him at the height of the tidal current in his tiny out-board motor boat (he knew nothing of boats) was high adventure. It was always great fun to share a platform with him; always there would be sprightly passages relieving the prose presentation of mere science. One of his brightest gems was after a colleague had drawn some endocrinological conclusions to which he could not subscribe, he remarked that it is easy to prove that a monkey is faster than a greyhound if you hold the race through the tree tops!

Therefore, not only do we mourn a gifted contributor to our science and art, but a personality outstanding for its warmth and vigor. The memory of Bill

will remain bright in the hearts of his friends. Medicine is the richer for his accomplishments but the poorer for loss of what more he might have accomplished had he been vouchsafed more years.

JAMES H. MEANS, '11

Reprinted from the November issue of the *Journal of Clinical Endocrinology and Metabolism*.

Necrology

1878

CLARENCE ALBERTUS VILES died at Salem, Mass., October 18, 1952.

1900

WILLIAM ELSTON LEIGHTON died at Kirkwood, Mo., November 9, 1952.

1901

GUSTAVE EMIL KURTH died at Lawrence, Mass., December 27, 1952.

1902

WILLIAM CARTER QUINBY died at Boston December 31, 1952.

APPLETON WHITE SMITH died at West Haven, Conn., September 14, 1952.

1903

HENRY DEMAREST LLOYD died at Boston, November 3, 1952.

WARREN DUNN RUSTON died at Chelsea, Mass., November 6, 1952.

GUY EDWARD SANGER died at Arlington, Mass., October 13, 1952.

1904

JOHN DONOVAN CLARK died at Putnam, Conn., September 20, 1952.

MARSHALL FABYAN died at Boston, October 19, 1952.

1905

JOSEPH JAMES HAGERTY died at Norwood, Mass., December 9, 1952.

1910

ROBERT WATSON HINDS died at Lake Worth, Florida, October 10, 1952.

1911

MILES FULLER PORTER, JR., died at Fort Wayne, Ind., September 4, 1952.

